DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 99-025

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/2/99

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 00 $183,360
b. FFY 01 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A
pages 5,6,18 & 19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A
pages 5,6,18 & 19

10. SUBJECT OF AMENDMENT: Adds 2.4% trend factor to per diem rates, adds 3.8% trend factor to trend costs for SFY 2000, removes growth factors from uninsured cost calculation and sets uninsured add-on payment at 82% of costs.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT JP ☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Gregory A. Vadner for

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director

15. DATE SUBMITTED:
December 13, 1999

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/14/99

18. DATE APPROVED:
AUG 28 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/02/99

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE: Acting
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Martin
Vadner
Waite

SPA CONTROL

Date Submitted 12/13/99
Date Received 12/14/99

FORM HCFA-179 (07-92)

Instructions on Back

$$\text{PER DIEM} = \frac{(OC * TI)}{MPD} + \frac{CMC}{MPDC}$$

1. OC-The operating component is the hospital's TAC less CMC;

2. CMC The capital and medical education component of the hospital's TAC;

3. MPD-Medicaid inpatient days;

4. MPDC-MPD as defined in III.A.3. with a minimum utilization of sixty percent (60%) as described in paragraph V.C.4.;

5. TI-Trend Indices. The trend indices are applied to the OC of the per-diem rate. The trend indices for SFY 95 is used to adjust the OC to a common fiscal year end of June 30;

6. TAC-Allowable inpatient routine and special care unit expenses, ancillary expenses and graduate medical education costs will be added to determine the hospital's total allowable cost (TAC);

7. The per diem shall not exceed the average Medicaid inpatient charge per diem as determined from the base year cost report and adjusted by the TI.

8. The per diem shall be adjusted for rate increases granted in accordance with subsection V.F., for allowable costs not included in the base year cost report

B. Trend Indices (TI). Trend indices are determined based on the four (4) quarter average DRI Index for DRI-Type Hospital Market Basket as published in Health Care Costs by DRI/McGraw-Hill for SFY 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on the CPI Hospital index as published in Health Care Cost by DRI/McGraw-Hill for each SFY starting with SFY99.

1. The TI are-

   A. State Fiscal Year 1994-4.6%.,
   B. State Fiscal Year 1995-4.45%;
   C. State Fiscal Year 1996-4.575%;
   D. State Fiscal Year 1997-4.05%;
   E. State Fiscal Year 1998-3.1%;
   F. State Fiscal Year 1999-3.8%
   G. State Fiscal Year 2000-4.0%

2. The TI for SFY 96 through SFY 98 are applied as a full percentage to the OC of the per-diem rateand for SFY '99 the OC of June 30, 1998 rate shall be trended by 1.2%and for SFY 2000 the OC of June 30, 1999 rate shall be trended by 2.4%.

IV. Per-diem Rate New Hospitals.

A. Facilities Reimbursed by Medicare on a Per-Diem basis. In the absence of adequate cost data, a new facility's Medicaid rate may be its most current Medicare rate on file for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for this third fiscal year will be the lower of the most current Medicare rate on file by review date or the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

B. Facilities Reimbursed by Medicare on a DRG Basis. In the absence of adequate cost data, a new facility's Medicaid rate may be one hundred twenty percent (120%) of the average-weighted, statewide per-diem rate for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for the third fiscal year will be the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

V. Administrative Actions

A. Cost Reports

1. Each hospital participating in the Missouri Medical Assistance Program shall submit a cost report in the manner prescribed by the state Medicaid agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). A single extension, not to exceed thirty (30) days, may be granted upon request of the hospital and the approval of the Missouri Division of Medical Services when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and post marked prior to the first day of the sixth (6th) month following the hospital's fiscal year end.

XVII. In accordance with state and federal laws regarding reimbursement of unreimbursed Medicaid costs and the costs of services provided to uninsured patients, reimbursement for state fiscal year 1999 (July 1, 1999 - June 30, 2000) shall be determined as follows.

A. Medicaid Add-Ons for Shortfall

The Medicaid Add-On for the period of July, 1998 to December 31, 1998 will be based on fifty percent (50%) of the unreimbursed Medicaid costs as calculated for SFY 1998.

B. Uninsured Add-ons

The hospital shall receive eighty-one percent (81%) of the Uninsured costs prorated over SFY 2000. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive eighty-two percent (82%) of its uninsured costs prorated over SFY 2000. The uninsured Add-On will include:

1. The Add-On payment for the cost of the uninsured. This is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio for allowable hospital services from the base year cost report's desk review. The cost of the uninsured is then trended to the current year using the trend indices in subsection III.B.. Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment; and

2. An adjustment to recognize the Uninsured patients share of the FRA assessment not included in the desk-reviewed cost. The FRA assessment for Uninsured patients is determined by multiplying the current FRA assessment by the ratio of uninsured days to total inpatient days from the base year cost report;

3. The difference in the projected General Relief per-diem payments and trended costs for General Relief patient days; and

4. The increased costs per day resulting from the utilization adjustment in subsection XV.B. is multiplied by the estimated uninsured days.

5. In order to maintain compliance with the BBA DSH cap and the budget neutrality provisions contained in Missouri's Medicaid Section 1115 Health Care Reform Demonstration Proposal, the Uninsured Add-On for SFY 2000 has been established at eighty-two percent (82%) of the cost of the uninsured as computed in accordance with this subsection. One factor in determination of the payment percentage is an estimate that $54 million

shall be paid from July, 1999 thru April 30, 2000 related to previously uninsured working parents covered under the Medicaid Section 1115 Health Care Reform Demonstration Proposal. The SFY 2000 payment percentage shall be increased by an additional one percent (1%) for every $3.5 million increment not paid for working parents covered under the Medicaid Section 1115 Health Care Reform Demonstration Proposal as of April 30, 2000. For example, if total spending on the Medicaid Section 1115 Health Care Reform Demonstration Proposal working parent population is $47 million, as of April 30, 2000, the Uninsured Add-On percentage for SFY 2000 shall be increased by two percent (2%).

XVIII. Medicaid GME Add-On -- A Medicaid Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a Medicaid managed care system such as MC+ in accordance with this section.

A. The Medicaid GME Add-On for Medicaid clients covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base year cost report shall be the fourth prior fiscal year (i.e., the base year for SFY 1999 is the FY 1995 cost report). The hospital per diem shall continue to include a component for GME related to Medicaid clients not included in a managed care system.

1. Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital's Medicaid population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars ($100,000), 2) forty percent (40%) of their Medicaid days are related to Medicaid recipients eligible for Medicaid managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars ($30,000).

2. The annual GME Add-On shall be paid in quarterly installments.